

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

34248

1. PLACE OF DEATH
94 County *St. Francois* Registration District No. *774*
5 Township *St. Francois* Primary Registration District No. *4465*
6 City *Flat River, Mo.* (No. St. Ward)

2. FULL NAME *Mrs. Viola Pratt*
(a) Residence, No. *Flat River, Mo. St.* Ward.
(Usual place of abode) (If nonresident, give city or town and State)
Length of residence in city or town where death occurred *20* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Female* 4. COLOR OR RACE *white* 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) *married*

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *Mr. Chas. R. Pratt*

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *July 4 - 1870*

7. AGE YEARS *63* MONTHS *3* DAYS *18* If LESS than 1 day, hrs. or min.

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. *Housewife*

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year) 11. Total time (years) spent in this occupation.

12. BIRTHPLACE (CITY OR TOWN) *Flat River, Mo.* (STATE OR COUNTRY)

13. NAME *Mr. Elias W. Williams*

14. BIRTHPLACE (CITY OR TOWN) *Mo.* (STATE OR COUNTRY)

15. MAIDEN NAME *Mary Schumacher*

16. BIRTHPLACE (CITY OR TOWN) *Mo.* (STATE OR COUNTRY)

17. INFORMANT *Mr. Bert Pratt Son* (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL
PLACE *Park View Cemetery* *Oct. 24* 19*33*

19. UNDERTAKER *Alvin W. Hood* (ADDRESS) *Flat River, Mo.*

20. FILED *10/25* 19*33* *C. B. Barrar* Registrar.

MEDICAL CERTIFICATE OF DEATH

1. DATE OF DEATH (MONTH, DAY, AND YEAR) *Oct 22* 19*33*

2. I HEREBY CERTIFY, That I attended deceased from *Oct 21* 19*33*, to *Oct 22* 19*33*

I last saw her alive on *Oct 22* 19*33*. Death is said to have occurred on the date stated above, at *2 P.* m.

The principal cause of death and related causes of importance were as follows:
arterial H. emphysema
82
Cause not known
Date of onset

Other contributory causes of importance *82*

Name of operation Date of
What test confirmed diagnosis? Was there an autopsy? *no*

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? Date of injury 19.....
Where did injury occur? (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury
Nature of injury

24. Was disease or injury in any way related to occupation of deceased? *no*
If so, specify
(Signed) *W. A. Ralston* M. D.
(Address) *Flat River, Mo.*

